Policy and Methods Used in Establishing Payment Rates for Each of the Other Types of Care or Service Listed in Section 1905(a) of the Act that is included in the Program Under the Plan.

I. General

A. The state agency will take whatever measures are necessary to assure appropriate audit of records wherever reimbursement is based on costs of providing care or service, or fee plus costs of material.

B. The state agency has access to data identifying the maximum charges allowed; such data will be made available to the Secretary of Health, Education and Welfare upon request.

C. Fee structures will be established which are designed to enlist participation of a sufficient number of provider and services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population.

D. Participation in the program will be limited to providers of service who accept, as payment in full, the amounts paid in accordance with the fee structure.

E. State payment will not exceed upper limits as described in regulations found in 42 CFR 447.250 - 447.371. Any increase in a payment structure that applies to individual practitioner services will be documented in accordance with the requirements of 42 CFR 447.203.

II. Clinic Services

A. Medicaid provider clinics are reimbursed at a fee-for-service rate established by the state. Payment will not exceed the prevailing charges in the locality for comparable services under comparable circumstances. Specialized clinics are reimbursed only for services the clinic is approved to provide.

B. Rural Health Clinics are reimbursed for rural health clinic services at a rate per visit established for the clinic by the Medicare carrier. Payment for ambulatory services, other than rural health clinic services, is at a fee-for-service rate established by the state. Reimbursement for Medicaid-Medicare patients will be that portion of reasonable charges assigned to the beneficiary.

C. Clinic Services in comprehensive outpatient rehabilitation facilities will be paid the lesser of Medicare's upper limits or the department's fee schedule.

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III. Physicians Services

A. Payments for physicians are the usual, customary, and reasonable charges by physicians up to a maxima specified by the department. The maximum allowable payment for most procedures is the product of Unit Values appearing in the department's fee schedule and a statewide Conversion Factor. For a few procedures, the allowed payment is not specified but payment does not exceed a reasonable charge.

B. The usual and customary charge is the fee charged by a physician to a majority of his/her patients.

C. Maximum fees are established and updated using a Resource Based Relative Value Scale (RBRVS) approach as adopted in the Medicare Fee Schedule (MFS). The MFS relative value units, adjusted by statewide geographic index, is multiplied by the statewide service-specific conversion factors.

IV. Pharmacy Services

A. General Information:

1. The state of Washington's Medical Assistance program will reimburse only for prescription drugs provided by manufacturers that have a signed agreement with the Department of Health and Human Services. Prescriptions for drugs may be filled and refilled at the discretion of the prescriber. For those drugs specified by the single state agency, prior approval will be required.

2. Payment for drugs purchased in bulk by a public agency will be made in accordance with governmental statutes and regulations governing such purchases.

3. Each Medical Assistance client is granted the freedom to choose his or her source of medications, except when the client is covered under a managed care plan which includes the drug benefit.

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B. Upper Limits for Multiple-Source Drugs:

1. The reimbursement amount for a multiple-source drug for which HCFA has established a specific upper limit shall be adopted, except, if the upper limit is lower than the pharmacies' actual acquisition cost for products available in Washington state. Based on information provided by representative pharmacy providers, a maximum allowable cost (MAC) shall be chosen. The chosen fee shall be the lowest amount sufficient to cover in-state pharmacies' actual acquisition cost. Payments for multiple-source drugs for which HCFA has set upper limits will not exceed, in the aggregate, the prescribed upper limits plus reasonable dispensing fees.

2. - The single state agency may establish a MAC for other multiple-source drugs which are available from at least three manufacturers/labelers. The MAC established shall not apply if the prescriber certifies that a specific brand is "medically necessary" for a particular client.

3. Automated maximum allowable cost (AMAC) pricing shall apply to multiple-source drugs which are not on HCFA upper limits or the agency's MAC list but are produced by three or more manufacturers/ labelers under the federal drug rebate agreement. AMAC reimbursement for all products within a generic code number sequence shall be at the estimated acquisition cost (EAC) of the third lowest priced product in that sequence, or the EAC of the lowest priced drug under a federal rebate agreement in that sequence, whichever is higher. AMAC is recalculated each time there are pricing updates to any product in the sequence.

4. The single state agency shall determine EAC by periodically determining the pharmacies' average acquisition costs for a sample of drug codes. The average cost shall be based on in-state wholesalers' published prices to subscribers, plus an average upcharge, if applicable. The single state agency shall pay the EAC for a multiple-source product if the EAC is less than the MAC/AMAC established for that product.

C. Upper Limits for "Other" drugs:

1. An "other" drug is defined as a brand name (single source) drug, a multiple-source drug where significant clinical differences exist between the branded product and generic equivalents, or a drug with limited availability.

2. Payments for "other" drugs are based on Average Wholesale Price (AWP) less a specified percentage. AWP is determined using price information provided by the drug file contractor.

D. Dispensing Fee Determination:

1. The department sets pharmacy dispensing fees based on results of periodic surveys.

2. The current dispensing fee payment system is multi-tiered. The dispensing fee paid to a pharmacy depends upon that pharmacy's total annual prescription volume (both Medicaid and non-Medicaid), as reported to the department.

3. Pharmacies providing unit dose delivery service are paid the department's highest allowable dispensing fee for unit dose prescriptions dispensed. All other prescriptions filled by these pharmacies are paid at the dispensing fee level applicable to their annual prescription volume.

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4. A dispensing fee is paid for each ingredient in a compound prescription.

V. Durable Medical Equipment

A. If an appliance is rented and subsequently purchased, the rental payment(s) must be applied to the purchase price.

B. If at any time the sum of the rental payments for which the division is responsible becomes equal to the current purchase price, the item will be considered paid in full.

VI. Dental Services

A. Payments allowed for dental procedures are the usual and customary charges by dentists and dental hygienists throughout the state up to the maximum established by the state agency. There are no geographical or other variations in the maximum charge allowed.

B. The usual and customary charge is defined as that fee usually charged for a given service by an individual dentist or dental hygienist to private patients (i.e., that provider's usual fee) and which fee is within the range of usual fees charged by dentists or dental hygienists of similar training and experience.

C. Auditing by the Department of Social and Health Services, Division of Medical Assistance, ensures the payment does not exceed the usual and customary charge filed by the individual dentist or dental hygienist.

VIII. Optometrists Services

A. Optometrists are reimbursed at their usual and customary charge or the maximum established by the department, whichever is less.

B. The usual and customary charge is defined as the fee charged for a given service by the provider to his private patients.

C. Information as to usual and customary charges as of January 1, 1969, was obtained from a survey conducted by the Washington Optometric Association. Schedules received by the SDPA from 236 optometrists (93 percent of the membership of the WOA) served as the source data for computation of 75th percentiles. Current fees are based upon that survey plus cost of living adjustments since that date.

D. To assure that payments do not exceed the customary charges of the individual practitioner, agreements with optometrists require a stipulation that charges to the department will not exceed their customary charges.

E. All requirements of 42 CFR 440.120 are met.

VIII. Institutional Services

A. Inpatient psychiatric facility services

Reimbursement rates for inpatient psychiatric services for individuals under the age of 21 in psychiatric facilities or programs will be established using a prospective rate setting system. These rates will be based upon preceding operating year cost reports.

B. Outpatient hospital services

Outpatient hospital services will be reimbursed utilizing either a prospective rate setting system based upon preceding operating year cost reports, or an agency fee schedule.

C. Free standing ambulatory surgery centers and other non-hospital based institutional services

Free standing ambulatory surgery centers and other non-hospital based institutional services will be reimbursed utilizing an agency fee schedule.

D. Payment Levels

The payment rates for the categories of services under A, B and C above will not be more than the prevailing charges in the locality for comparable services under comparable circumstances, in accordance with the provisions of 42 CFR 447.321 or 447.325.

IX. Other Noninstitutional Services

A. The upper limit for payment will be prevailing charges.

B. Home Health Agencies are reimbursed per visit for services provided by professional staff and by home health aides.

C. Day Health Care Clinics are reimbursed at a flat fee per day per recipient for all services rendered. Payment will not exceed the prevailing charges in the locality for comparable services under comparable conditions.

D. Payment for medically necessary transportation services provided by nonprofit organizations may be based on the operating costs incurred in providing the service or the rates established by the department, whichever is lower.

X. All Other Practitioners

All other practitioners are reimbursed at usual and customary charges up to a maximum established by the state.

XI. Prepaid Capitation Arrangements

The upper limit for payment for services provided on a prepaid capitation basis shall be established by ascertaining what other third parties are paying for comparable services under comparable circumstances. The cost of providing a given scope of services to a given number of individuals under a capitation arrangement shall not exceed the cost of providing the same services while paying for them under the requirements imposed for specific provider services.

XII. Laboragory and Pathology Services

Payments made for laboratory and pathology services will be either Medicare laboratory rates (60 percent of the statewide prevailing charge screen) or rates established by the department, whichever is lower.

XIII. Targeted Case Mangement Services

A. Recipients Manifesting Pathology with Human Immunodeficiency Virus (HIV)

Payment will be on a monthly capitation post-pay, firm-fixed price basis. The upper limit for payment for services provided on a capitation basis shall be based on an estimate of the fee for providing the services.

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IX. Other Noninstitutional Services (Cont.)

E. Family Preservation Services

Payment for FPS is on a fee-for-service basis. Payment rates will be determined prospectively and based on allowable operating costs from the most recently submitted cost report. They will be reconciled to actual costs yearly. The total payment will also be adjusted for cost and volume (i.e., number of children served) increases or decreases reflected in annually submitted budgets.

F. Behavior Rehabilitation Services

Payment for behavior rehabilitation services is on a fee-for-service basis, with one month being the unit of service. Rates are determined using a prospective rate setting system. These rates will be reconciled annually and adjusted as appropriate based upon preceding operating year cost reports.

X. All Other Practitioners

All other practitioners are reimbursed at usual and customary charges up to a maximum established by the state.

XI. Prepaid Capitation Arrangements

The upper limit for payment for services provided on a prepaid capitation basis shall be established by ascertaining what other third parties are paying for comparable services under comparable circumstances. The cost of providing a given scope of services to a given number of individuals under a capitation arrangement shall not exceed the cost of providing the same services while paying for them under the requirements imposed for specific provider services.

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XII. Laboratory and Pathology Service

Payments made for laboratory and pathology services will be either Medicare laboratory rates (60 percent of the statewide prevailing charge screen) or rates established by the department, whichever is lower.

XIII. Targeted Case Management Services

A. Recipients Manifesting Pathology with Human Immunodeficiency Virus (HIV).
Payment will be on a monthly capitation post-pay, firm-fixed price basis. The upper limit for payment for services provided on a capitation basis shall be based on an estimate of the fee for providing the services.